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ABSTRACT

The medical student's emotions during direct clinical contact with the human body were studied, with emphasis on strategies the student uses to manage feelings when they are "inappropriate" or uncomfortable. Observations and interviews were completed over a 2-year period (1984-1986). Observations were made in the gross anatomy laboratory, physical diagnosis course, and in clerkships. Interviews were conducted with 16 first-year, 13 second-year, 15 third-year students, and 18 others including residents and nurses. The interviews covered the major body contact situations including dissection and practice sessions on physical examination skills. Three emotion management strategies were identified: concentration on positives, intellectualization, and avoidance. Seven facts about the curriculum can influence the student's experience and emotion management strategies, including: the curriculum emphasizes the biomedical; the patient's affect is secondary to biomedical considerations; and there is no place in the formal or informal curriculum for the student's affect. (SW)

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FROM PERSONAL TO PROFESSIONAL: The Medical Student's Effort to Gain a Professional Perspective for Physical Intimacy

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INTRODUCTION

"How do I set aside 25 years of living? Experience which made close contact with someone's body a sensual event? Maybe it's attraction, maybe disgust. But it isn't supposed to be part of what I feel when I touch a patient. I feel some of those things, and I want to learn not to." This question, asked by a third year medical student, is inherent in medical education because body contact in our personal lives prompts feelings which are considered inappropriate in the physical intimacy of medicine. (1,2,3,4) Intimacy in the personal world involves issues of aesthetics, morality, power, selectivity, sensuality, and sexuality, all of which are outside the explicit ideals of medicine.

Medical ideals, particularly in the context of a biopsychosocial model (5) and the call for increased humanism in medicine, emphasize the importance of the physician's sensitivity to the patient's emotions. In terms of the physician's own emotions, as distinct from his behavior, the ideals suggest that he will experience* contact with the patient's body only in terms of the patient's well being. Proscribing a range of behaviors, the ideals are less clear about emotions, but suggest that many emotions imply some kind of failure in the physician. It has been acknowledged that medical students (6,7), and physicians (8) do experience feelings which do not resonate with professional ideals. At a behavioral level, the student's efforts to hide his emotions behind a "cloak of competence" have been described in detail. (3,9,10,11) But the student expects to develop a professional perspective for body contact which will minimize the kinds of feelings we consider natural, though not always pleasant, in the personal world.

The transition from a personal to a professional perspective for body contact represents a fundamental and difficult challenge faced by the students individually and collectively. (12) Starting with the personal meanings they attached to the body and body contact before entering medical training, enduring meanings learned through "primary socialization" (13), students must independently and mutually define and incorporate new meanings appropriate to the profession and to the particular environment of the school. (14) When

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* I have chosen to use the singular in order to maintain a focus on the individual's feelings. This decision led directly to the problem of sexism in my language. Respectful of the women students involved in this study, I worked with a variety of stylistic alternatives, but I have returned to the use of "he" and "his" for several reasons. I recognize the danger in this, and encourage the reader to read this report as the story of all the individual students who contributed to the study.

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This study analyzes the medical student's emotions during direct clinical contact with the human body, and emphasizes the strategies the student uses to manage feelings when they are "inappropriate" or simply uncomfortable. Based on observation and interview data collected from first, second and third year students over a two year period, the authors describe three emotion management strategies: concentration on positives, intellectualization, and avoidance. In their variations, most strategies do diminish the students' attention to psychosocial factors. There is no discussion of emotions or management strategies in the formal or informal curriculum, and the content and structure of the curriculum support the students' strategies, though both emotions and mangement strategies influence the medicine the student learns and practices.

their feelings are either uncomfortable or inappropriate, they must find ways to manage them. (15)

Three research questions guided this study. 1. What feelings does the medical student have during moments of direct professional contact with the human body? 2. What efforts does the student make to manage his feelings, beneath his behavioral presentation? 3. What social and curricular factors influence the student's feelings and his efforts to manage them? Given the significance of body contact in the personal world, answers to these questions may be related to the quality of the student's interactions with patients, to his convictions about the psychosocial aspects of medicine, and to his personal well being.

METHOD

The exploratory, descriptive nature of the study demanded a naturalistic research strategy. Focusing upon students in the first three years of training at one medical school, the methodology evolved over a two and a half year period (February 1984 to August 1986) as suggested by Guba's notion of sequential waves of exploration and verification. (16) In three separate waves, we observed for a total of 35 hours in the Gross Anatomy laboratory, 34 hours in the Physical Diagnosis course (classroom, session on the pelvic examination, and practice with patients) and 168 hours in the five third year clerkships. Other sites entered the data through interviews. The sites were selected to cover the major body contact situations including dissection, practice sessions on physical examination skills, and services in the clerkships where contact with the breasts, genitals and rectum is nominally routine. We selected the sites without knowing which students were assigned there.

Over the same period we conducted progressively focused interviews with 16 first year, 13 second year and 15 third year students, and 18 others including residents, attendings, nurses, spouses and counselors in the student health service. (Spouses and counselors were interviewed as one basis for triangulation.) Primary student respondents were recruited from the students we met in the observational sites. Secondary respondents were recruited from others we met during informal discussions of the project, and on the basis of different views evident in the discussion.

The data were analyzed in a framework which evolved with the study. As issues emerged, field notes were reviewed, coded and recoded according to our own interpretations, which were then checked with respondents and with two faculty members who did not participate in the field work. The framework was generally revised three times, and then refined in detail. Toward the end of the study, we recruited seven students, four residents, and three clinical faculty members to critique a draft report, specifically requesting suggestions to bring the report into line with their own experience and their sense of the issues. Their reactions were strongly supportive. Support from students has continued in their reactions to short presentations of the study to small groups in a first year course (Introduction to Medicine). Throughout the study we received support and guidance from three members of the clinical faculty, and two faculty members trained in qualitative research methodology.

FINDINGS

Findings are reported here in terms of the three research questions. It is important to note that different students experience different combinations of feelings and employ different combinations of emotion management strategies. Furthermore, students react differently to different contact situations. The feelings and strategies described here, however, capture the experience of a majority of the students involved in the study. It is also important that this report represents a summary of the comments and behaviors of many students.

The Student's Feelings

The student's feelings ordinarily exist in vague clusters, generally within the student's awareness but rarely distinct. The combinations include comfortable and uncomfortable feelings based on a variety of issues, including some which are not directly related to contact. Contact sometimes serves as a stimulus which brings other issues and feelings to the surface.

> (Second year student) "I have always felt a sanctity for the body. Something like personal space, which is important in this country. The pelvic was harder. I hadn't seen or done one before, and I was anxious in several ways. I am getting interested in OB/GYN as a field. The world of pregnancy and childbirth is interesting. And I was afraid that I wouldn't be able to relate to it, like a friend who really loves the liver, relates to it. I wasn't sure I could relate to the pelvis. I was worried that it might affect the way I relate to women in general, and that's scary..... I was also anxious that I might not be objective, like I might get aroused. It feels like breaking some taboo. Who am I to be looking in there, and putting my fingers inside? I also wondered if the model (in the training session) would be attractive, and she was. And I worried that I might be incompetent, hurt her.... I had fun last night, organizing this speech, getting ready to talk to you. It helped me get it straight, begin to understand."

This "speech" contains clear elements of several of the separate feelings described below. From the student's perspective, however, it is a clearer statement of his emotional experience than he would ordinarily achieve. This student reflected on his experience for some time in preparing for his interview. Like many others, he ended the interview by thanking us for the opportunity to clarify and discuss his experience. The vague quality of his normal experience is itself the basis for some discomfort.

Beginning in the anatomy lab and continuing through the clerkships, students describe several strong, comfortable feelings which arise from direct contact with the human body. Several are clustered around the progressive acquisition of the role of "physician." There is excitement in the anatomy lab since it symbolizes the actual beginning of medical study. "This is the part that is really medical school. It feels like an initiation rite, something like when I joined a fraternity. We were really going to work on people." The excitement dwindles after the first few days, but returns in some degree as the student progresses toward "real" medical situations, many of which involve body contact.

There is also a vivid sense of the physician's privilege in body contact. The student realizes that the physician is granted a unique access to the body, in the anatomy lab as well as in the examining room, and feels grateful at the beginning. The sense of privilege is gradually replaced by a feeling that it is the student's right and responsibility to contact the body, and both of these later images are heightened as competence is learned. In the second and third years, the student also begins to feel a sense of power, recognizing that the patient will do nearly anything he asks. "There I was, a second year medical student who didn't know much of anything, and I could have done anything I wanted. He would have done anything I told him." Another feeling becomes real in the clerkships. The student enjoys a sense of satisfaction and achievement in beginning to offer some assistance to the patient.

Contact also provides a basis for important learning. The student senses that he is learning something important in contact, something richer than the scientific, cognitive facts of textbooks and lectures. In simple terms, the student comes to understand details and acquire skills which had been entirely abstract before contact.

> (First year student) "Like with the heart, it was learning. Wow! This is the heart. Wonder what chamber this is."
>
> (Second year student) "Drawing blood,,,with some it's hard to get their blood, finding their veins. But I got good. With my experience my sensitivity increased. I could feel veins when others couldn't.... And I got more confidence. I got better. It was skills."
>
> (Second year student) "It's great. I've always been interested in the body, curious about how it works. Like why your arm goes to sleep when you put it over the back of a chair."
>
> (Third year student) "It was exciting. I saw the scars on her abdomen, a lot of them. Then I noticed some facts in her chart. And people were commenting that she is strange. Suddenly I remembered a lecture from last year. The professor said there is one specific problem which is often misunderstood. They often start doing abdominal surgery. And then the medications make it worse, the psych symptoms get worse. They often end up in psych hospitals. It all fit together. Then, when the resident found that one strange lab value everyone had missed, we could really see it."

In direct contact, abstractions begin to have a more lively meaning which the student can associate with the actual practice of medicine. More generally, he senses a coming together of concrete and abstract knowledge which combine to produce understandings essential to medicine. For some, the combination satisfies a long standing curiosity.

For some students, learning goes beyond the acquisition of new knowledge and skills. Contact often yields an intellectual fascination which seems different from the "rational, analytic" thinking the student sees as officially important.

(First year student) "I appreciate the body more, like a work of art. It's so much more than I'll ever know."

(First year student) "I guess I learned the intuitive part in the practice sessions (on physical examination skills.) After all that training in science, this was different. Kind of like a brick layer. When he's good, he can just feel if it's right, without using his ruler all the time.... Like feeling someone's side. Feeling,,,,it begins to mean something. All the courses don't mean anything till I have them in my fingertips."

(Second year student) "I could see the details I had studied.... I saw them and I touched them. The words and the,,,,personality of the details."

(Second year student) "The bi-manual (in the pelvic exam) was different. Like I knew what I was supposed to feel, but I didn't feel anything. Like when you palpate the spleen. Most people never feel it. So this is just another of those. I had read the book on the exam, and it seemed like an ancient rite. It felt good to have a sense of it after that evening."

All of this learning seems to be outside the explicit curriculum evident in the student's classes. The notion that a part of the body could have "personality" and that the student could "relate" to it (as with the liver and pelvis above) was difficult for the student to explain, but it is part of his experience. Similarly, the student recognizes that intuitive thought is enhanced in contact, and he respects it though he realizes that intuition is different from the analytic judgement explicit in the curriculum. And there are times when he senses that he is not only learning, but participating in some kind of "rite" which may be important in medicine even if the nominal lessons involved seem artificial.

As a symbol of medicine and as concrete experience, body contact plays an important part in these comfortable feelings. Without contact, the experience would be comparable to other professional training. Mixed with the pride the student feels in earning the rights of the physician, he knows that he is learning, at several levels. The combination is gratifying in terms of examinations, the student's self image, and the simple pleasure of new understanding.

At the same time, however, learning is one basis for the student's discomfort. As learning proceeds, the human body is gradually but officially secularized, lifted out of the romantic and mysterious meanings which attached to it in the student's life before medical school. The shift is vaguely uncomfortable. "The heart,,,it's just a blood pump." "It's (the breast) just a lump of fatty tissue with some glands and ducts. Maybe it will be exciting some new way." "The Father part is gone. This is just the body." "You know, when I was getting into some of the micro courses I felt like I didn't want to learn any more. I want it to stay a friend or lover, not just a biomedical machine. They want us to think about the body that way. But,,,," "This (the cadaver) is pretty much like the deer I cleaned last Fall. Drier, and harder. But, like this muscle,,,,then we ate it. It's just like any meat." From the

objective perspective the student is learning, the body is "just" a complex thing to be understood like any other thing, including other animals and food. There is an unspoken, philosophical change, and the student is not sure what the body will become in his life, what new meaning it will have.

Evidence of the changing set of meanings attached to the body at school, the student experiences new feelings in moments of contact at home. His experience at school spills over into his personal world. For some the effect is comfortable. For others it is not.

> (First year student) "I have learned enough to find gross problems. And they taught us that breast cancer is one of the biggest threats to a woman's health. OK. So I can offer my expertise. But I found myself examining her, right in the middle of making love. Not cool!"

> (Second year student) "I'm starting to see that touching is good, valuable to others. My relationship with patients is different, but I can carry it back into my personal life. I had fallen way behind in touching. It had gotten so touching wasn't an option for me. But I'm catching up. It's an option. It's allowed.... Like I've been blocking on touching every time. But with patients I get beyond the blocks, and I can sense a little of what it's like. Look! I'm out here beyond the blocks, and it's OK! Then I can try a little more in my personal life,,,, But it's not changing fast."

> (Second year student) "I'm sure glad I could talk about it with my wife. It felt like something about my masculinity. In GYN you don't think so much in sexual terms, not with that big piece of metal (the speculum) in her. But there's no metal at home, and I still don't feel the same about it. They say you get over this pretty quick. I wonder how."

Comfortable or uncomfortable, these feelings suggest the significance of the change inherent in medical training. The student is vaguely confident that the uncomfortable at-home effects will not continue, that he will become flexible enough to shift back to a personal, subjective perspective when he leaves the hospital. But he is not sure. If learning can be gratifying, it can also be disruptive.

Similarly, the process of acquiring the role of physician involves uncomfortable as well as comfortable feelings. The student is conscious that some aspects of his training are extreme, even bizarre or immoral when seen from the personal perspective he knew for "25 years" before entering medical school. Certain dramatic acts such as dissection and the autopsy intensify the issues.

> (First year student) "Doing the pelvis, we cut it across at the waist, and up through the crotch. Big saws! The mad scientist! People wouldn't believe what we did in there. The cracking sound! That day was more than anxiety. We were really violating that person,,,, Drawn and quartered."

> (Second year student) "She just looked asleep. Not like the cadaver. Fluid, blood, smell. It smelled like a butcher shop. And they handled it

> like a butcher shop. The technicians. Slice, move, pull, cut. All the organs, insides, pulled out in ten minutes. I know it's absurd, but what if she's not really dead? She doesn't look like it."

The "mad scientist" and the "butcher" have not been part of the student's image of medicine. Such extremes are unsettling, even as the student recognizes that they are not and will not be routine. Even in more routine kinds of contact, however, he sometimes feels that he is violating the sanctity of the body or basic social taboos. While he believes abstractly in the legitimacy of clinical contact, in his right and responsibility to contact the body, he is aware that clinical contact requires a new morality as well as new knowledge.

Increasing knowledge, skill and confidence add individual reality to the abstract right he is earning, enough to produce a sufficient rationale for proceeding with most contact. Further, as the student's role changes, as he becomes a member of a clinical team in the third year, he believes that he can offer something through contact.

> (Third year student) "The big difference is in our role. Now I'm a contributing member. Before, they just used to sneak us in (to the patient's room). Now, I'm right in there, doing something for the patient, not just for myself."

> (Third year student) "Last year, with patients I was only learning. Now, contact is just part of the job, part of a good exam. I'd be cheating the patient if I didn't do it. And it's basically non-intrusive. There's no pain."

With some qualifications, contact is appropriate. Though he complains at other times that his role as a clerk is to "get the scut work done," that he is not really admitted into the clinical process, he sees his skills and his role as adequate to justify at least some kinds of contact. But the student is often hesitant himself, and sensitive to excess in others.

There are a number of other uncomfortable feelings associated with body contact. The student knows fear during contact, fear of rejection by peers and faculty, fear of missing critical learning points and clinical facts, and fear of hurting the classmate, model or patient. The fear is based upon immediate demands and the responsibility which the student anticipates after graduation. There is also fear that other uncomfortable feelings might arise and become apparent to others or disrupt the work at hand.

Much of the student's discomfort is based on the fact that the body he contacts belongs to a person. Attached to a person, the body has personal meanings which are the basis for discomfort.

> (First year student) "When we had them dismembered (in dissection) they were less human from that point on. It got easier. It was tough when we had to turn the whole body over from time to time. It felt like real people. It got easier when it was just a leg, and everything else was covered up."

(First year student) "I have thought of him as a family man. Thought a lot about it. Where are his kids? Are they angry at us for doing this to him? My father is sick, and I have been comparing him to this."

(First year student) "We found the tumor, in her breast, that killed her. A spongy tumor. I have a friend. Her mother has one and they don't know what it will be,,,, I know her."

In the anatomy lab, the "person part is gone." But the student can imagine him or her, and he can identify with the disease, and with death. He can imagine his friends, his family and himself suffering the disease and the extremes of medical treatment. He can sense the finite limits of his professional capacity against the fact of death. As contact comes to involve a living other, the student must also contend with the other's feelings, including the distress which he must cause in the process of treatment. From the beginning, he realizes that it is not so difficult when the body is not so much "like real people."

Contact with the sexual body is particularly confusing. Watching classmates take off their shirts for "surface anatomy" on the first day in anatomy lab, the student is challenged immediately to approach contact professionally. It is not easy.

(First year student) "How come we all should take our shirts off? Sounds simple, right? Take your shirt off so the others can examine your back. Taking your shirt off is not simple! We didn't really have to, and I'm glad. Don't know what I would have done if they had pressed the point. It would have been enough for two of us in each group. Why all of us?"

(First year student) "We were shocked when some of the girls took their shirts off! I left the room when I saw them taking shirts off, automatically thinking 'I don't belong here.' Then, in the hall, I felt 'that's silly,' and went back in. I just can't look at that professionally yet. Wonder if it's part of a plan to desensitize us."

In the vivid juxtaposition of healthy, attractive classmates and the cadaver, the student is asked to consider them equivalent. He can recognize that the bodies are similar in the official perspective, but he brings his personal perspective with him into the lab, and the two are apparently incompatible. The difference in perspectives is not easy for the student to understand. Noticing that some of the women are wearing bras and others bathing suit tops, he notes that "a bra and a bathing suit are pretty much the same. What's the difference? Don't know, but there is one." His question stands for a much more general issue, and he knows it.

Later, during contact with the sexual body in dissection, in practicing examination skills with classmates, in the special session on the pelvic examination, and in "sensitive" examinations in the clerkships, the student feels a tension between the personal and clinical perspectives.

(First year student) "I could look, not real easy. But I couldn't touch it (the penis in dissection.) Touching is different. I was conscious of

it all the way through the lab, and we had, what, five sessions on it? Even with the skin off, I could still see what it was. The internal part was OK, but not the outside, the part you could see."

(Second year student) "We just did stethoscopes, blood pressures (in the practice examinations with other students.) Most of the girls did it with other girls. The whole group of four, not just the pairs. We wore bathing suits, but there was some touching. It was pretty close."

(Third year student) "Sometimes with the pelvic it's the smell. Sometimes it's bad, bad but mostly OK. But sometimes it reminds me that it's a woman. Somehow,,,, I just didn't expect the woman smell."

(Third year student) "My first patient was a young girl, fourteen years old. I had been told she was a pediatrics patient, but I sure didn't expect a fourteen year old,,,,and well developed. I think she was promiscuous.... I had heard about moving the breast around to listen to the heart, but it was hard with this girl. I forgot to do the heart at first, went all the way to the end and then said, 'I'll have to listen to your heart.' It was extremely uncomfortable."

Though he is actually aroused only rarely, the student worries that he will be, and sometimes that he is not. He feels guilt, knowing that sexuality is proscribed in medicine. At the same time, he feels excitement at learning, passing important landmarks and hurdles, and overcoming anxiety. Sensitive contact is experienced in terms of both the personal and professional perspectives, almost simultaneously. "I tried to do it with minimum contact, without staring at her tit,,,breast.... The different words, shows I was feeling both things at once." "If they asked me to cough (for a hernia examination), I'd do it. Blush and go ahead. It's both." Feelings arising from the personal perspective are uncomfortable, and the concurrent experience of both perspectives is confusing.

Finally, the student feels disgust. The aesthetic details of many situations are simply repulsive. Seeing feces, smelling vomit(us), touching wounds, hearing bone saws; the student is close to many ugly details with all of his senses. Some details are masked behind the constant smells, wrappings and drapes, but many are unavoidable. He feels nausea, revulsion and an inclination to move away. But in most situations he cannot leave or grimace. The social pressure and the ideals of medicine force him to stay, and to remain poised. Internalizing this pressure, the student feels inadequate because he feels squeamish.

Accepting that he must change to live with body contact in medicine, the student is aware of a potential problem. Often using the word "desensitization," he worries that medical training will dull him to emotions too generally or too constantly. Success in controlling or eliminating the uncomfortable feelings may itself represent a different kind of problem.

(First year student) "I think we're all getting jaded. You don't look too comfortable with this (dissection), but we are, partly. Don't know how that happened. I don't like the word jaded. Don't want to be jaded."

(Second year student) "Those feelings just get in the way. They don't fit, and I'm going to learn to get rid of them. Don't know how yet, and some of the possibilities are scary. Maybe it's just a matter of doing these things more often. But we just don't really have a choice."

(Third year student) "It's kind of dehumanizing. We just block off the feelings, and I don't know what happens to them. This is pretty important to me. I'm working to keep a sense of myself through all this."

Within a wider concern about his life as a person, the student worries that he will lose the capacity to be sensitive to his patients, to others in his life, and to himself. Recalling complaints about insensitive physicians and noting the apparent insensitivity of some faculty and students, he hopes to become flexible, able to set feelings aside or to attend to them as appropriate. Generally confident that he will succeed, he does not understand the process, and he realizes that this part of his education is happening behind the scenes. His feelings about contact are normally hidden behind the cognitive demands of the curriculum and his continuing concern about learning enough.

Emotion Management Strategies

In general, the student is aware of his uncomfortable feelings in vague combinations. Partly because of the academic and social pressure, he is rarely aware of them clearly or individually. But he is often uncomfortable, and feels the challenge to overcome the feelings and the general tension between the personal and professional perspectives.

(First year student) "It wouldn't be a problem if I weren't in medicine. But doctors just aren't supposed to feel that way." (Interviewer) "How do you know?" (Student) "I don't know how, just sense it. It's macho, the control thing. Like, 'med student, get a grip on yourself.' It's just part of medicine. It's a norm, expected."

The challenge is seen in traditionally masculine terms: "screwing up your courage," "getting control of yourself," "putting feelings aside," and "being macho enough." Some students, men and women, dislike these terms and the imagery they imply, but they do not see clear alternatives. Privately, and sometimes very consciously, they use four strategies to manage their emotions.

The simplest strategy involves the fact that the student often experiences comfortable and uncomfortable feelings in the same situation. It is often possible to minimize discomfort by concentrating on the comfortable feelings.

(First year student) "I can't remember what it was like before coming. It's enveloping. When I wake up I start thinking about being in med-school. It's like a honeymoon, knowing I'll be an MD some day. It's just a real good feeling. I don't know how long it will last, and the work is demanding, almost all my time. But it's real, and it does make gross (lab) easier."

(Second year student) "If it's something uneasy, like moving her to listen to her heart, I also know that I'm doing the right thing. It's

both, and it feel good to know I'm doing it right."

(Second year student) "I know he is embarrassed. I would be." (Interviewer) "Are you embarrassed too?" (Student) "Yeah,,, Maybe part of it's mine. Not just his. Embarrassed isn't quite the right word. Uneasy. But he might be embarrassed too!"

Both general and specific, comfortable feelings can serve to mask the uncomfortable. "I am practicing good medicine," for example, can override "I am feeling disgusted." "I am sensitive to the patient's embarrassment" can override "I am embarrassed myself." This strategy requires the student to recognize the comfortable feelings which occur naturally, or to manufacture them as necessary. In the latter case, the student sometimes distorts the situation. The patient may not in fact be embarrassed, or promiscuous, or scared, but the student may exaggerate signs that these feelings are present, or assume them, in order to produce a comfortable feeling sufficient to override his own discomfort. In attending to the patient the student is living the ideals of medicine, and he is proud of himself. If the patient's feelings are important, even as potentials, it is also true that concentrating upon them serves to diminish certain of the student's feelings. Empathy can be both an appropriate attitude and an emotion management strategy.

The second strategy is essentially intellectual. The student attempts to concentrate on medical facts about the body and sub-personal details of the body, knowing that these details have no personal significance, no personal meanings.

(First year student) "We would look real hard for some specific thing, and lost the sense of its being a person. Concentrating. And having a precise goal cut down the time we had to reflect, to feel anything."

(Second year student) "I just told myself, 'OK, doc, you're here to find out what's wrong, and that includes the axillaries.' And I detach a little, reduce the person for a moment. Like ignore the crying. Focus real hard on the detail at hand, the fact, or the procedure or the question. Like with the cadaver. Focus on a vessel. Isolate down to whatever you're doing. It works, and it makes sense for a moment." (This student had earlier called the axillaries "smelly armpits," and noted how repulsive she sometimes finds them.)

(Second year student) Well, with the pelvic training, I realized that those women volunteered to do it, and they've done it many times before. I concentrated on the procedure, the sequence and the motions. And some of it was interesting.... With the 22 year old, I concentrated on the order, sequence and on the details to check."

Feeling guilty about "mangling" the cadaver, a student criticizes his dissection group for their levity and begins to ask difficult questions about nerves in the neck. Feeling "uneasy" attempting the pelvic exam, another student concentrates on the Bartholin gland. The anatomical details, facts and procedures they focus on have little personal significance. Similarly, emotions can be minimized by concentrating on data about the body such as lab

values, diagnostic labels and abnormalities. Employing these variations of the intellectualization strategy serves a dual purpose. It focuses the student's attention on certain clinically relevant factors, and it renders the body non-personal. The body is not simply a complex object. It is a collection of innumerable smaller objects in a complex system. Hoping to remain flexible enough to disengage the strategy when it is no longer necessary, the student contacts the complex object, not the human body he has known. If the secular body is a disruptive notion, it is also emotionally neutral as an object.

The variations of the intellectualization strategy are supported by the use of the scientific, clinical language the student is learning. It is a complex, esoteric language devoid of personal meanings. Individual words suggest new meanings to replace the meanings attached to the layman's words. "Palpating his abdomen" is different from "feeling his belly," though the student sometimes realizes that they are also very similar.

> (First year student) "When we were dissecting the pelvis, the wrong words kept coming to mind, and it was uncomfortable. I tried to be sure to use the right words, penis and testicles, not cock and balls. Even just thinking. Would have been embarrassing to make that mistake that day. School language, it made it into a science project."
>
> (Third year student, speaking to a young woman just before the pelvic examination) "Just take off your jeans and your panti,,,,underpants, and sit on the edge of the table. I'll be right back."

Further, the structure of the language, as in the standard format for the presentation of a case, assists the student in both thinking and speaking impersonally. Again, the strategy serves a dual purpose, labelling and conveying clinically relevant information, and leading the student away from his emotions.

A third strategy involves mentally transforming the body into a non-personal object which the student can contact with more comfortable and appropriate emotions. Visualizing the body as some kind of machine or a non-human specimen, and recalling earlier experience working on such an object, the student is able to make contact without the personal feelings he wishes to control.

> (First year student) "After we had the skin off, it was pretty much like a cat or something. It wasn't pleasant, but it wasn't human either."
>
> (Second year student) "This exam (the pelvic exam) is pretty much like checking a broken toaster. It isn't a problem. I'm good at that kind of thing. (His image is challenged by the instructor and another student.) There are a thousand things wrong with the image, but in a way it does make sense."
>
> (Third year student) "You can't tell what's wrong without looking under the hood. It's different when I'm talking with a patient. But when I'm examining them it's like an automobile engine.... There's a bad connotation with that, but it's literally what I mean."

(Third year student) "The patient is really like a math word problem. You break it down into little pieces and put them together. The facts you get from a history and physical, from the labs and chart. They fit together, once you begin to see how to do it."

The student can transform the moment of contact into something about which he has comfortable memories and confidence, including the kind of intellectual challenge he has faced successfully during years of earlier classes. As the student progresses from challenge to challenge in his training, he collects experience to support the transformation strategy. Success in managing the anatomy lab provides clues on how he can manage later challenges. The transformations contain elements of the original situation. The body can be understood as comparable to an automobile engine. They omit other elements, however, those elements which were the basis for discomfort.

Finally, the student can simply avoid certain kinds of contact which give rise to unwanted emotions. There are two basic variations of the avoidance strategy: controlling the visual field during contact, and eliminating or reducing particular kinds of contact.

(First year student) "We did make sure that it was covered. The parts we weren't working on. The head, the genitals. All of it really. It was important to keep them wrapped and moist, so they wouldn't get moldy. That made sense. But when the cloth slipped, someone made sure to cover it back up, even if just a little (pubic) hair showed."

(First year student) "I had most trouble with the genitalia.... Quite an ordeal. Taking the skin off. The girls did the actual dissection. I went into the corner and read. Turned my back. Didn't want to be involved."

(Second year student) "At the genitals, I was embarrassed. I had never touched a guys genitals before. Even though this was medical, it was a pretty quick exam. I mimicked the preceptor, but I didn't really have any knowledge of it. It was not comfortable."

Keeping personal body parts covered in the lab and in examinations removes disturbing visual facts. This variation also serves two purposes. Professionally, it serves to prevent mold or maintain asepsis and to protect the patient's modesty. Personally, it protects the student from his feelings. On occasion the latter purpose is primary. Some students, for example, examine the breasts by reaching under the patient's gown, by-passing the visual examination emphasized in training.

In another form avoidance means abbreviating or eliminating certain parts of the examination, moving or looking away, or choosing to be absent from certain situations. Absence is usually not an option, but many students use the less obvious variations. The student explains his limited and "deferred" examinations with reference to his inexperience or the patient's needs, noting that "four or five others will be doing it. Why should I make the patient uncomfortable?" But some acknowledge that this rationale is a convenient disguise for their effort to avoid or postpone sensitive contact.

Social and Curricular Factors

Social:

Discussion of emotional experience is not an acceptable emotion management strategy. The students rarely discuss their experience with other students, or with the faculty.

> (First year student) "I would be embarrassed to talk about it. You're supposed to be professional here. Like there's an unwritten rule about how to talk."
>
> (Interviewer) "Do you ever talk like this with other students?" (Second year student) "Zero. When the others are talking it's usually about unusual stuff, like jokes about huge breasts.... But I'd imagine that most students have pretty much the same feelings I do. They sweat too, in the pelvic session, and they make jokes too often. But,,,, I don't have a sense of how the female students feel about any of this, about examining the male genitals."
>
> (Second year student) "We do talk (among friends.) Inadequacy is a big one. Like I can't hear heart murmurs at all. But not on embarrassment... Maybe some talk with good friends, one to one. Or sometimes it's joked about, specially by people in urology."
>
> (Second year student) "I can imagine the faculty saying something abstract. But nothing real. I think this kind of issue is just too remote for them now."
>
> (Third year student) "The folks who shut their feelings off, they change too. For instance, the anatomists. They're wonderful people, but they have no empathy. I guess after 15 or 20 years of dissecting they simply forget the feelings we might have getting started. They just forget. I wonder how they must change doing it for so long."

While the student's experience exists in a continuing and obvious social silence, the "unwritten rule" about explicit discussion is sometimes relaxed. There is occasional discussion among students, in private and with "one or two good friends." Some individual faculty members and residents initiate limited discussion, and there are a few comments offered in class, e.g., "You can expect to be aroused sometimes, examining an attractive woman." But these are rare exceptions which occur according to individual initiative. Students recognize that the abrupt, exaggerated and often sexual humor common in their informal conversation, and in many of the faculty's comments, reflects a common difficulty with feelings. They find further evidence in other students' gestures at difficult times. But this confirmation is limited. These informal signals blur the edges around the official perspective which the curriculum provides, but give only limited permission to experience contact in personal terms.

Tacitly, the students and the faculty agree that feelings exist, but that they are not to be discussed or displayed. The agreement does provide for

indirect expression in humor and in subtle gestures, but the student is essentially alone with his feelings. The social silence conveys the message that the student's feelings are officially inappropriate, that he should overcome his feelings, and that he must manage his feelings individually. Many believe that others are handling the challenge more adequately than they are.

If the quality of the social agreement is essentially uniform among the students and faculty, there is variation in the character of discussion the student finds with others in his life. For those who are married or have partners, the support or tension the student experiences in these primary relationships is important.

> (First year student) "She's been really interested in what I'm doing. Lots of times I'll touch something on her and we'll talk about it. She says it's almost like she is learning too. It's been fun, and practice for me."
>
> (Third year student) "When I was doing GYN,,,,well, she knew and she waited. I think she understood better than I did. I guess it was strange for her, too, but she let me wait a while before trying to say anything."
>
> (First year student) "My husband didn't like the idea of surface anatomy. I knew I had to tell him before I did it. He told me to wear a bra you couldn't see through. That was the hard part, dealing with my husband."
>
> (Third year student) "The other day I was just touching her back. It's something I like to do, and it felt like a way to,,,,touch her. But she asked me, 'find anything wrong?'"

Perhaps reflecting broader issues in the relationships, these comments suggest the significance of discussion at home, with primary partners. Those with supportive partners are pleased and proud. Those without are envious. Family and friends are typically curious, perhaps fascinated with some of the student's dramatic experience. But they normally indicate that there are limits to the range of details they want to hear, perhaps uncomfortable themselves with the possibility that physicians have feelings too.

Curricular:

Seven major facts about the curriculum stand out as significant in influencing the student's experience and emotion management strategies. First, the curriculum is emphatically biomedical, stressing the concrete, detailed systems and sub-systems of the human body in health and disease. Illustrating the complexity of the body as it is formally understood, it is not studied as an entity, but intellectually broken down and studied in terms of systems defined by 20 courses in the first two years. The concrete, objective emphasis is maintained through the third year despite the shift to an educational focus on current patients.

Second, restating the emphasis on biomedicine, the patient's affect is minimized in the formal conception of medicine the student learns. Affect is presented as important at a few points in the curriculum, and it is sometimes

acknowledged at the beginning or end of otherwise biomedical classes. Individually, some faculty members model a genuine regard for the patient in psychosocial terms, but they are not typical and their approach is not officially reinforced. The student meets many faculty who have little apparent regard for the patient's feelings beyond basic human consideration, and too many who are inconsiderate. In general, the patient's affect is definitely secondary to biomedical considerations in the official model of medicine.

Third, there is no place in the formal or informal curriculum for the student's affect. In some small group situations there are occasional moments when the faculty's feelings become apparent or when the possibility of strong feelings in medicine is recognized. But these rare moments are not built into the curriculum intentionally; they occur at the initiative of individual faculty members. Implicitly, the student is taught that his own feelings are irrelevant and inappropriate.

In general, the formal curriculum separates the body from the affective life of the patient and sets the student's affect aside entirely. The body is a complex, mechanical thing made up of an overwhelming number of complex, mechanical things and understood in objective, mechanical terms. The person of the patient is understood as something separate from the body, and at least relatively unimportant. The person of the student is understood as something separate from the analytic mind, and irrelevant, perhaps dangerous in medicine.

Fourth, it is important that a large majority of the student's contact with the body is indirect. Direct contact represents just ten percent of the student's school time in the first three years. (See Table 1.) There is no person in the body the student contacts on the printed page, in photographs and in laboratory data. The student can imagine the person involved in some indirect contact, but many of the verbal and visual images are of physical details which would require intellectual reassembly before taking on human meaning. He can associate medical records and X-rays with the patients he contacts directly, but discussions in the clerkships include minimal reference to the patient's feelings, values or subjective circumstances.

Furthermore, approximately 45% of the student's direct contact occurs in the anatomy lab, where facts about the cadaver and the technical focus on the inside of the body distract the student from the fact that he is contacting what remains of a person. Contact with living others represents only four percent of the student's class time over the first three years, and only three percent in the first two years. Together with the substance of the curriculum, this fact illustrates the official, objective perspective for the human body and for body contact.

Fifth, the student's direct contact with patients is unsupervised in both the second and third years. When the faculty are present they make the contact themselves, leaving the student to observe. In one sense, the lack of supervision provides the student with freedom to develop his own techniques without the pressure of criticism. In another sense, it provides freedom to modify contact according to the student's comfort. He is free to proceed on his own initiative.

Table 1.
Summary of Class Hours and Estimates of
Direct Contact Hours in the First Three Years

Year	Total Class Hours	Direct Contact Hours	Percent Of Class Time In Direct Contact	Percent Of Class Time In Contact With Living Others (C)
First	857	130	15%	1%
Second	881	36	4%	4%
Third	2400 (A)	120 (B)	5%	5%
Total	4138	286	7%	4%

(A) Estimated at 50 hours per week for 48 weeks.
(B) One-half of estimated 10% of total time spent with patients.
(C) (Direct Contact Hours - 120 Hours Dissection) / Total Class Hours

Sixth, The student is constantly under several kinds of pressure. The reality of a range of knowledge which far exceeds the student's capacity to learn provides a continuing challenge to concentrate which is reinforced by the competition for grades among the students and intensified by reference to the ideal of the thoroughly competent physician. Formal and informal evaluation is a part of the student's life; it is a nearly constant part of the third year. Despite the very low attrition rate, and driven by the competition for acceptance into residency programs, the student invests very long hours in the struggle. At one level, the struggle is focused on the objective substance of the formal curriculum which supports the intellectualization strategies. At another, the familiar fatigue blunts the student's feelings, an anesthesia under which the student lives and studies and contacts.

Seventh, at the informal level there is evidence that the formal definitions and images of the body and body contact are unrealistic. There is a boundary line around the most personal parts of the body, a line which the student is only occasionally expected to cross. There is no pressure to continue with surface anatomy; the students discontinue it after the first three or four sessions. There are limits on the range of physical examination skills the students practice with each other and in the gynecological training session (the student does not examine the breasts and does not conduct the rectal component of the examination in this special session.) There is a policy excluding the genitals and rectum in practice sessions with patients in the second year. The student is rarely challenged on his decision to "defer" the breast, rectal and genital examinations in the clerkships, and he realizes that the faculty also abbreviate contact.

(Third year student) "Mostly, they don't do the breasts, pelvic or rectal. We had a woman with a vaginal discharge (noted in the chart), but I didn't do a pelvic on the work-up. Almost never. Sometimes a quick external check. That is the extent of their concern. For most docs and residents those are outside their area of expertise. If they think an exam should be done, they call in a consult, like GYN..... On medicine, the rectal is often important. I did a couple. Hopefully, the resident or attending did it. We thought we should do screening on the breasts, but I only did one or two."

(Third year student) "If you skip the genitals or rectal, and you note 'exam deferred' in the chart, there's no problem. Sometimes they tell you to go ahead and do it, but there's no problem. So long as they don't think you just forgot. Just say 'pelvic deferred.'"

All of this indicates an informal acceptance that the sexual parts of the body are subjectively different. The difference is described in terms of the patient's sensitivity. But it is accurate to add that the subjective difference exists for the faculty and students as well, though it is not discussed. To some degree, the silent acceptance of the boundary illustrates the fact that the body cannot be fully understood in the objective terms of the formal curriculum.

In summary, the curriculum presents the student with significant challenges in body contact. But the substance of the curriculum, the lack of supervision in contact, the continuing pressures, the faculty's model and the accepted boundary line all reduce the challenge and support certain emotion management strategies. The curriculum includes the challenge and implicitly provides acceptable solutions which are partially effective. Because the student relies upon these solutions, the circular process is self sustaining. The educational and medical models are reinforced by the students reliance on the solutions implicit in them.

In that these social and curricular factors shape the student's feelings and reinforce his emotion management strategies, they can be considered collective management strategies, established as a part of the culture of medical education in part because of their moderating effect on the student's (and perhaps the faculty's) emotional experience. This is not to suggest that they cannot be explained in other terms as well. But their influence in moderating the discomfort involved in the physical intimacy of medicine does suggest that they are serving two important purposes, just as many individual strategies serve dual purposes.

CONCLUSIONS AND IMPLICATIONS

It is apparent that students at this medical school do not learn a perspective for body contact sufficient to eliminate feelings of fear, guilt, embarrassment, arousal, disgust or confusion in moments of body contact. There are comfortable feelings too, but uncomfortable and "inappropriate" feelings continue through the clerkships. Anxious to overcome them, concerned about the potential implications of success and contained by the social silence, the student attempts to manage his feelings with strategies which do reduce his

discomfort. Most of the strategies involve approaching contact from a perspective which reduces or eliminates the person in the body he contacts, or reducing the quantity and range of contact he makes. Several factors in the curriculum directly support these strategies, though the student's problem in adjusting to clinical contact is not officially addressed. The student makes the adjustment privately.

It is clear that the emotions which arise during body contact can affect the student's behavior both in the immediate situation and more generally, whether or not the student acts them out. As their intensity increases, and according to the student's thresholds, emotions can permeate the student's awareness and limit his abilities to reason or perform. Accepting that the student's feelings are natural, and that he must manage them at times to insure adequate clinical performance, the quality and implications of the strategies he uses become significant.

The emotion management strategies the student uses have implications for the quality of the medicine he learns and practices. Up to the point where he begins to manufacture comfortable feelings, the student's efforts to "accentuate the positive" do not distort the situation or affect the range of factors he acknowledges. He remains relatively free to attend to a full range of clinically relevant facts. But as he begins to manufacture feelings, to intellectualize or transform the body, and to avoid contact, he is actively limiting his perception of the situation to exclude those elements which provoke his uncomfortable feelings. In general, he sets aside most of the details which attach a person to the body he contacts. The remaining details are important in medicine, but the student's awareness is narrowed, and the elements he excludes are relevant depending upon the model of medicine in which they might be considered.

In a biomedical model, intellectualization and transformation can lead the student directly to critical facts. But these strategies, avoidance and the distortions which enhance comfortable feelings can lead the student away from factors which are important in terms of clinical indicators, compliance and simple consideration. In a biopsychosocial model, those aspects of the patient and the doctor-patient encounter which are effectively set aside are central to the definition of the model and significant in terms of the doctor-patient relationship. In this sense, the student adopts a limited biomedical model as he employs these strategies. He takes what appears to be a philosophical stance for psychological reasons.

Depending upon the model against which the implications are judged, the quality of the student's emotion management strategies and his flexibility in fitting them to specific situations are significant outcomes of his medical training. But, perhaps because the student's strategies represent an element of the culture of medicine, these outcomes are part of the hidden curriculum, unofficially shaped but officially ignored. The possibility of developing alternative strategies and increasing the student's flexibility in using them defines a worthwhile research agenda.

It is also plausible to reason that the quality of the student's adjustment to clinical body contact, particularly in combination with the other

adjustments he must make, may influence his satisfaction with the practice of medicine and his individual well being. Noting that a desire to help people is one part of the student's interest in medicine, the process of depersonalizing the patient may represent an important, continuing frustration. Individually, and depending upon how the adjustment plays out in the context of the student's life more generally, the clinical perspective he learns may disrupt important personal relationships and sensitivities. The human body, body contact and natural emotions are experientially and philosophically significant elements of the student's and the physician's lives as people. Medical training implicitly initiates a process of change to establish new kinds of significance consistent with the practice of medicine. The change may alter the quality of their lives apart from medicine. These possibilities, implying a need for flexibility in moving between the professional and personal worlds, also suggest research directions.

In simplest terms, learning a perspective for the physical intimacy in medicine is a difficult challenge with significant implications, both real and potential. The psychosocial dimension of the medical student is directly affected and in turn affects his private life as well as his relations with patients. This sequence deserves thoughtful attention within and beyond the context of undergraduate medical education.

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